| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395892 | A. Building<br>B. Wing | 01/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kadima Rehabilitation & Nursing at Latrobe | 576 Fred Rogers Drive<br>Latrobe, PA 15650 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>31760<br><br>Based on observations, staff and family interviews, and review of cleaning schedules, it was determined that the facility failed to provide a clean and homelike environment in residents' rooms for five of 12 residents reviewed (Residents 6, 8, 9, 10, 11)<br><br>Findings included:<br><br>Observations of Resident 6's room on December 30, 2024, at 12:45 p.m. and 2:30 p.m. revealed that the resident's privacy curtain was pulled around the foot of the resident's bed. The resident's privacy curtain had multiple colored stains that extended from the bottom of the curtain and upward approximately one-quarter the way up on the privacy curtain. The privacy curtain between the resident and her roommate had a reddish-colored stain to the bottom corner of the privacy curtain. Interview with the resident at 12:45 p.m. revealed that she could not recall when her room was cleaned last.<br><br>Observations of Residents 8 and 9's room on December 30, 2024, at 12:41 p.m. and 2:30 p.m. revealed multiple food debris on the floor between the residents' beds.<br><br>Observations of Residents 10 and 11's room on December 30, 2024, at 12:35 p.m. and 2:30 p.m. revealed that there was multiple food debris on the floor between the resident's beds and an area under the foot of the bed by the door that had dried fluid from a spill.<br><br>Interview with Housekeeper 1 on December 30, 2024, at 1:29 p.m. revealed that the privacy curtains get washed monthly or when the room gets deep cleaned when a resident changes rooms or is discharged .<br><br>Interview with the Nursing Home Administrator on December 30, 2024, at 2:30 p.m. confirmed that Resident 6's privacy curtains needed cleaning and that they should have been should have been changed over the weekend and also confirmed that the rooms of Residents 8, 9, 10, and 11 needed to be cleaned.<br><br>28 Pa. Code 207.2(a) Administrator's Responsibility. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>19102<br><br>Based on review of facility policies, job descriptions, staff education records, clinical records, and investigation reports, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect while being transported to dialysis for one of 12 residents reviewed (Resident 1), resulting in harm to Resident 1 due to a fall that resulted in a fracture.<br><br>Findings include:<br><br>The facility's policy regarding abuse and neglect, dated November 24, 2024, indicated that the resident had the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. Neglect was defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect referred to failure through inattentiveness, carelessness, or omission to provide timely, consistent, safety adequate, and appropriate services, treatment of care, including but not limited to: nutrition, medications, therapies, and activities of daily living.<br><br>The facility's transportation policy, dated November 24, 2024, revealed that all employees who operate a vehicle would receive, upon hire, training in bus/van policies, procedures, and operations. Additionally training was to be provided on a regular basis. Both staff and clients were to wear a seatbelt at all times when the vehicle was in operation and clients in wheelchairs were to be secured with the use of wheelchair locks, as well as either a lap belt or shoulder safety belt.<br><br>The job description for the transportation driver, undated, revealed that the driver was to perform all assigned tasks in accordance with established policies and procedures, and as instructed by their supervisor, and was to ensure a safe environment.<br><br>Education records for Van Driver 3, dated October 4, 2024, revealed that he received training on the transportation policy and procedures.<br><br>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 29, 2024, revealed that the resident was cognitively intact, had limited range of motion to her upper and lower extremities, used a wheelchair, received dialysis services, and had diagnoses that included renal failure. The resident's care plan, dated November 26, 2024, revealed that she required dialysis on Mondays, Wednesdays, and Fridays.<br><br>A nursing note, dated December 24, 2024, at 9:20 a.m. revealed that Resident 1's wheelchair tipped over backwards while in the facility's van. On assessment by the Director of Nursing and the Registered Nurse Supervisor, Resident 1 was already returned to the upright position and being secured to the van. Resident 1 stated that her chest hurt and that her knees hit her in the chest when she tipped over backwards. She refused any further assessment and requested to go ahead to dialysis. At 11:31 a.m., dialysis sent the resident to the local hospital for further evaluation and treatment.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Hospital records, dated December 24, 2024, revealed that Resident 1 reported that she was on her way to dialysis via a wheelchair van and when they attempted to start moving, her wheelchair was not locked into place, and she was ejected from her wheelchair. Her knees subsequently struck her chest, specifically her sternal (bone located in center of the chest) area. She admitted to a marked amount of sternal pain since then. A CT scan (diagnostic test) report revealed that the resident had an age indeterminate, possibly chronic, sternal fracture deformity. This was to be correlated clinically at the point of tenderness in this location. Hospital records revealed that the resident was made aware of the concerning CT scan findings for a sternal fracture, and she was agreeable to transfer. Given the traumatic findings found on the scan as well as the need for emergent dialysis, she required a transfer.<br><br>Resident 1 was transferred as a Level 2 trauma (a patient with a traumatic injury that is considered potentially life-threatening, meaning they have significant injuries but are currently stable with vital signs within normal ranges, requiring immediate specialized care at a Level 2 trauma center) to a hospital in Pittsburgh. A review of hospital records from Pittsburgh, dated December 24, 2024, through January 2, 2025, revealed that Resident 1 was admitted to ICU for acute respiratory insufficiency requiring significant respiratory support, treatment for a sternal fracture, and dialysis.<br><br>Information submitted by the facility, dated December 24, 2024, revealed that Resident 1 was being transported to her dialysis appointment in the facility van and when the van was pulling out of the driveway, which had a slight upward grade, Resident 1's wheelchair tipped backwards causing the resident to hit her head. She reported that her chest hurt from her knees coming up and hitting her chest. Resident 1 stated that she was okay and was transported to dialysis. The facility received a call from dialysis that they were sending Resident 1 to the hospital for evaluation and treatment and that the resident sustained a sternal fracture.<br><br>The facility's investigation, dated December 24, 2024, revealed that the straps to hold Resident 1's wheelchair in place in the van were not secured properly.<br><br>A statement from Nurse Aide 2, dated December 24, 2024, revealed that when the transport van went to pull out of the parking lot she heard a loud noise, and when she looked back she saw that Resident 1's wheelchair tipped backwards. The resident stated that her chest hurt from her knees hitting her chest.<br><br>A statement from Van Driver 3, dated December 24, 2024, revealed that when he was hooking up Resident 1's wheelchair to the back chair locks, he got distracted when someone asked about hooking up their seat belt, and he did not lock the front of Resident 1's wheelchair to the chair holders.<br><br>An interview with the Director of Nursing on December 30, 2024, at 12:29 p.m. confirmed that Van Driver 3 did not lock Resident 1's wheelchair properly, which resulted in her falling backwards.<br><br>28 Pa. Code 211.10(c)(d) Resident Care Policies.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>19102<br><br>Based on review of facility policies, clinical records, and facility investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that the residents' environment remained as free from accident hazards as possible for one of 12 residents reviewed (Resident 1) who used a wheelchair, resulting in a fracture.<br><br>Findings include:<br><br>The facility's transportation policy, dated November 24, 2024, revealed that all employees who operate a vehicle would receive, upon hire, training in bus/van policies, procedures, and operations. Additionally training was to be provided on a regular basis. Both staff clients were to wear a seatbelt at all times when the vehicle was in operation and clients in wheelchairs were to be secured with the use of wheelchair locks, as well as either a lap belt or shoulder safety belt.<br><br>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 29, 2024, revealed that the resident was cognitively intact, had limited range of motion to her upper and lower extremities, used a wheelchair, received dialysis services, and had diagnoses that included renal failure. The resident's care plan, dated November 26, 2024, revealed that she required dialysis on Mondays, Wednesdays, and Fridays.<br><br>A nursing note, dated December 24, 2024, at 9:20 a.m. revealed that Resident 1's wheelchair tipped over backwards while in the facility's van. On assessment by the Director of Nursing and the Registered Nurse Supervisor, Resident 1 was already returned to the upright position and being secured to the van. Resident 1 stated that her chest hurt and that her knees hit her in the chest when she tipped over backwards. She refused any further assessment and requested to go ahead to dialysis. At 11:31 a.m., dialysis sent the resident to the local hospital for further evaluation and treatment.<br><br>Hospital records, dated December 24, 2024, revealed Resident 1 reported that she was on her way to dialysis via a wheelchair van and when they attempted to start moving, her wheelchair was not locked into place and she was ejected from her wheelchair. Her knees subsequently struck her chest, specifically her sternal (bone located in center of the chest) area. She admitted to a marked amount of sternal pain since then. A CT scan (diagnostic test) report revealed that the resident had an age indeterminate, possibly chronic, sternal fracture deformity. This was to be correlated clinically at the point of tenderness in this location. Hospital records revealed that the resident was made aware of the concerning CT scan findings for a sternal fracture and she was agreeable to transfer. Given the traumatic findings found on the scan as well as the need for emergent dialysis, she required a transfer.<br><br>Resident 1 was transferred as a Level 2 trauma (a patient with a traumatic injury that is considered potentially life-threatening, meaning they have significant injuries but are currently stable with vital signs within normal ranges, requiring immediate specialized care at a Level 2 trauma center) to a hospital in Pittsburgh. A review of hospital records from Pittsburgh, dated December 24, 2024 through January 2, 2025, revealed that Resident 1 was admitted to ICU for acute respiratory insufficiency requiring significant respiratory support, treatment for a sternal fracture, and dialysis.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Information submitted by the facility, dated December 24, 2024, revealed that Resident 1 was being transported to her dialysis appointment in the facility van and when the van was pulling out of the driveway, which had a slight upward grade, Resident 1's wheelchair tipped backwards causing the resident to hit her head. She reported that her chest hurt from her knees coming up and hitting her chest. Resident 1 stated that she was okay and was transported to dialysis. The facility received a call from dialysis that they were sending Resident 1 to the hospital for evaluation and treatment and that the resident sustained a sternal fracture.<br><br>The facility's investigation dated December 24, 2024, revealed that the straps to hold Resident 1's wheelchair in place were not secured properly.<br><br>A statement from Nurse Aide 2, dated December 24, 2024, revealed that when the transport van went to pull out of the parking lot she heard a loud noise, and when she looked back she saw that Resident 1's wheelchair tipped backwards. The resident stated that her chest hurt from her knees hitting her chest.<br><br>A statement from Van Driver 3, dated December 24, 2024, revealed that when he was hooking up Resident 1's wheelchair to the back chair locks, he got distracted when someone asked about hooking up their seat belt, and he did not lock the front of Resident 1's wheelchair to the chair holders.<br><br>An interview with the Director of Nursing on December 30, 2024, at 12:29 p.m. confirmed that Van Driver 3 did not lock Resident 1's wheelchair properly, which resulted in her falling backwards.<br><br>28 Pa. Code 211.10(c)(d) Resident Care Policies.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services. |